Department of HUMAN SERVICES

Health Home Learning Collaborative

Chart Review Workbook Process

September 2021

This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid Enterprise

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Learning Objectives

- Review: Health Homes (HH) strengths and opportunities for improvement
- Documentation:
  - What are we looking for in the charts?
- Crisis planning:
  - Addressing behavioral health/physical health crisis plans with members
  - Alternatives to Emergency Department (ED)
  - Who is responsible for monitoring plan?

Learning Objectives, con't.

- Use of SMART goals
- Decreasing ED utilization
  - Education: alternatives to the ER for care
- Medication reconciliation
- HH/PCP collaboration
  - How is the HH utilizing the RN on staff for education or follow-up?
  - Documenting care coordination
  - Follow-up on referrals- what is the process?

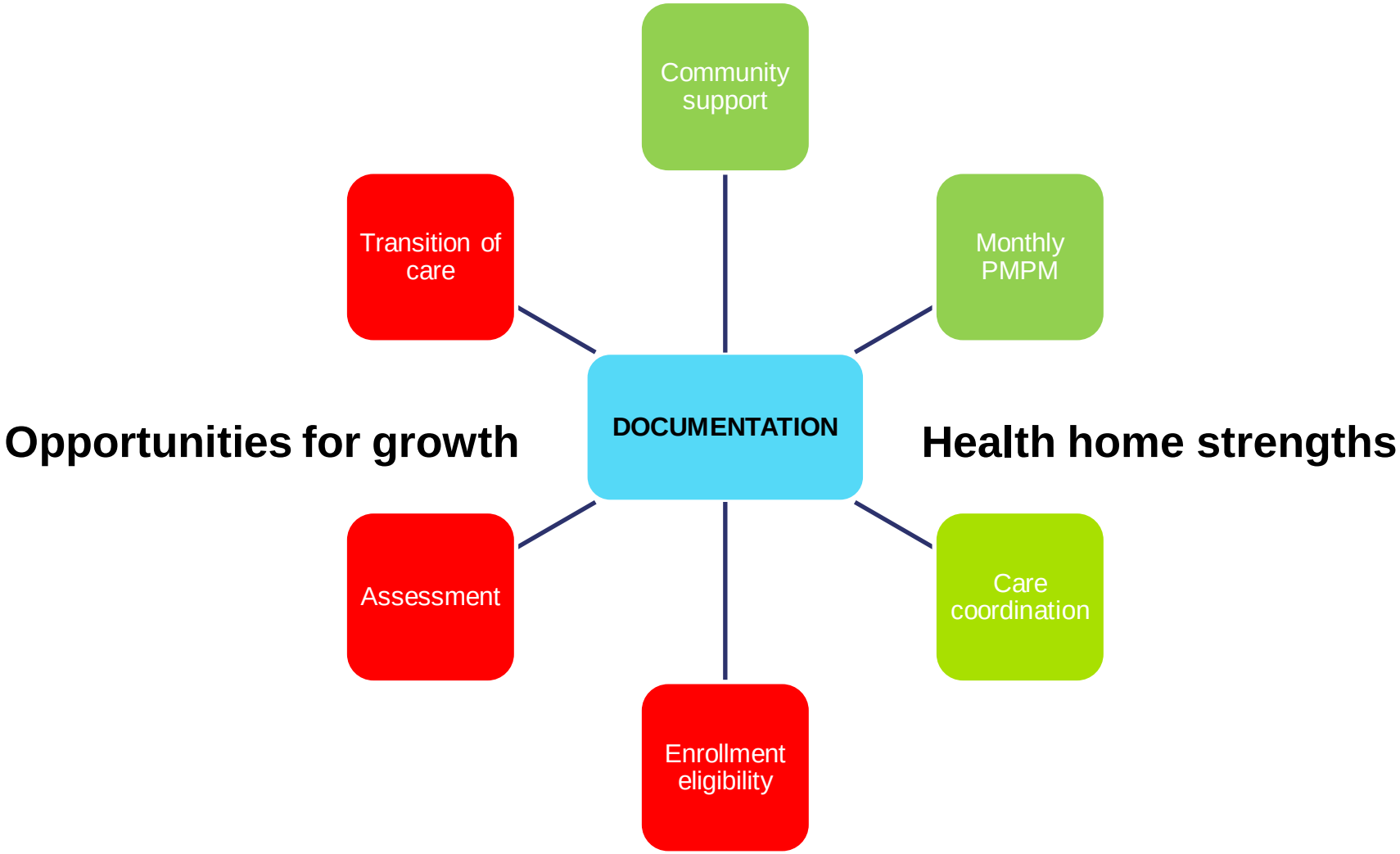
Learning Objectives, con't.

- Transition of Care
  - Transition w/in the community: hospital to home, skilled care, group home, etc.
  - Communication b/w HH and hospital: discharge planning
  - Communication/Collaboration with community service providers
  - 2-day f/u with member; medication management
  - Case Notes : what is expected in the documentation?
  - ADHD/HTN/Chronic disease education
    - HEDIS Guidelines

Review: what we do well and where can we make improvements

HEALTH HOMES: STRENGTHS AND OPPORTUNITIES

Common threads



What are we looking for in our chart audits?

DOCUMENTATION STANDARDS

What are well documented case notes?

- Individualized
- Personalized
- Meaningful statements in notes
- Member responses, understanding

Individualized - Personalized

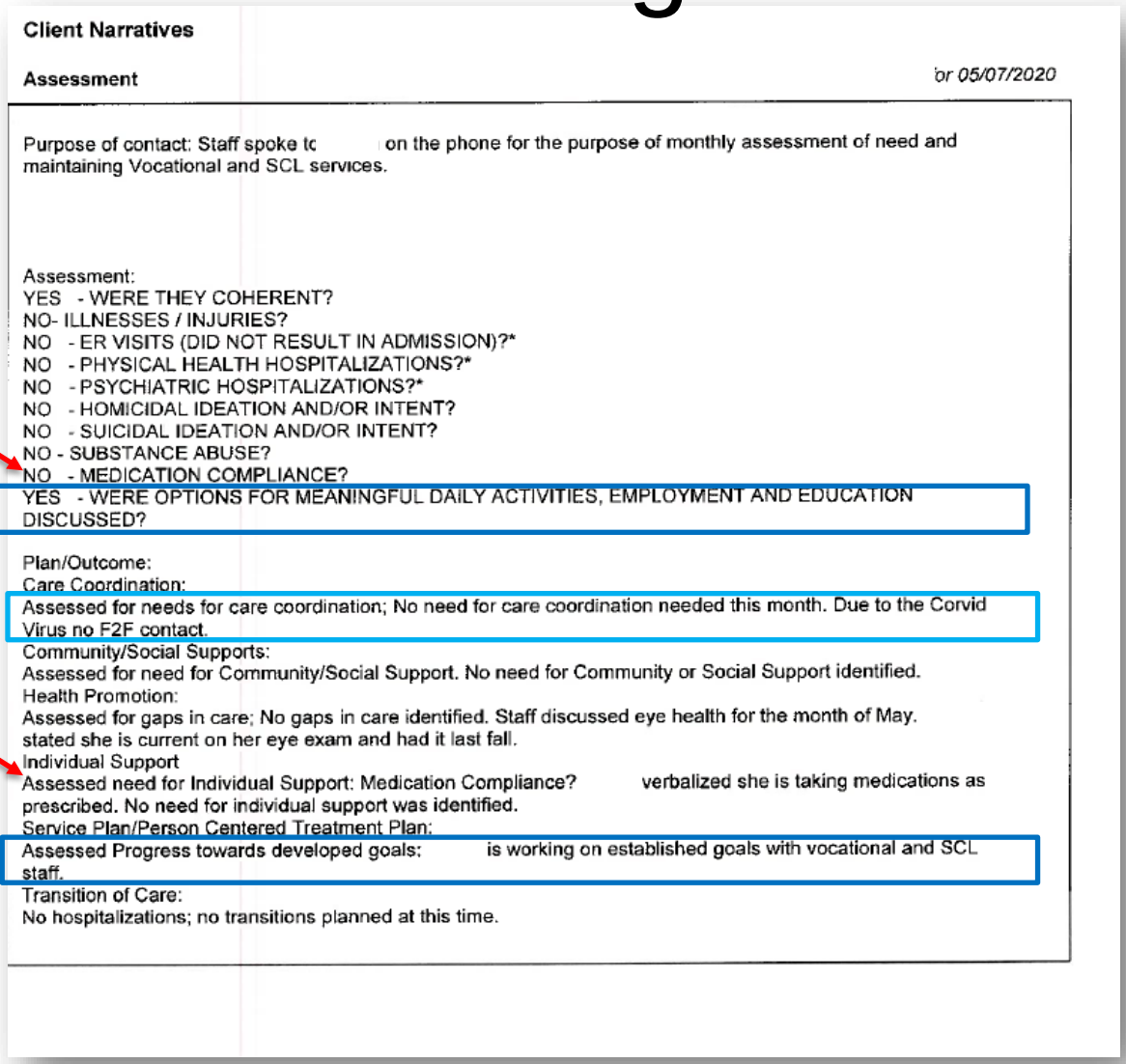
Crisis plan: Crisis plan: Crisis plan: In the event of a medical emergency, should contact 911 or go to the nearest emergency room. In the event of physical illness that is not life threatening should contact their primary care physical or use the local Urgent Care clinic to avoid unnecessary ER utilization. In the event of a psychiatric emergency should call 911 or go to the nearest emergency room. In the event of a mental health crisis, she should utilize their natural support system and crisis plan, as well as contact professional supports. reports indicators she is not doing well is when she has the urge to self-harm. USUAL COPING STRATEGIES: makes sure she is taking his medications and knows when to go to the emergency room. WHAT TO DO/ INTERVENTIONS agreed to contact staff at the when she has the urge to self-harm. She will also confide with close friends and family. NATURAL SUPPORTS/FRIENDS, FAMILY, OTHERS: utilizes her friends to help her to manage her mental health symptoms. she is also familiar with what to do in the event of a fire and has both smoke detectors and fire extinguishers. She will evacuate the home with the nearest and safest exit, staying low to the ground to avoid smoke inhalation. Once safely outside of the home, will use own cell phone to call 911 for assistance. She is familiar with what to do in the event of a tornado or inclement weather. In the event of a tornado, client will go to the basement or an interior room away from any windows and wait for an all clear signal. will follow all protocols for work or locations away from their home.

Is it meaningful?

PROCESS FOR REQUESTING UPDATES:
IHS Care Coordinator will receive at least quarterly updates from the provider regarding Joe's progress. Joe is able to request an update at any time from the provider or from his care coordinator.

This member's name was **Sarah**.

Meaningful?



Client Narratives

Assessment *or 05/07/2020*

Purpose of contact: Staff spoke tc on the phone for the purpose of monthly assessment of need and maintaining Vocational and SCL services.

Assessment:
YES - WERE THEY COHERENT?
NO- ILLNESSES / INJURIES?
NO - ER VISITS (DID NOT RESULT IN ADMISSION)?*
NO - PHYSICAL HEALTH HOSPITALIZATIONS?*
NO - PSYCHIATRIC HOSPITALIZATIONS?*
NO - HOMICIDAL IDEATION AND/OR INTENT?
NO - SUICIDAL IDEATION AND/OR INTENT?
NO - SUBSTANCE ABUSE?
NO - MEDICATION COMPLIANCE?
YES - WERE OPTIONS FOR MEANINGFUL DAILY ACTIVITIES, EMPLOYMENT AND EDUCATION DISCUSSED?

Plan/Outcome:
Care Coordination:
Assessed for needs for care coordination; No need for care coordination needed this month. Due to the Corvid Virus no F2F contact.
Community/Social Supports:
Assessed for need for Community/Social Support. No need for Community or Social Support identified.
Health Promotion:
Assessed for gaps in care; No gaps in care identified. Staff discussed eye health for the month of May. stated she is current on her eye exam and had it last fall.
Individual Support
Assessed need for Individual Support: Medication Compliance? verbalized she is taking medications as prescribed. No need for individual support was identified.
Service Plan/Person Centered Treatment Plan:
Assessed Progress towards developed goals: is working on established goals with vocational and SCL staff.
Transition of Care:
No hospitalizations; no transitions planned at this time.

Now, this is good!

— Note

CC provided Health Promotion and Individual and Family Support:
CC texted .

Greetings !! This is , your PIHP Care Coordinator from . I just wanted to reach out and see how everything is going for you and . I have attached the COVID Recovery Iowa Flyer that provides information on ways to obtain free counseling, group activities and support group and resources. I also have an additional New COVID hotline # 800-362-2736. If you have any further questions or concerns please text or call me on my cellphone # . Hope you had a Happy 4th of July!!!
With warm regards,

PIHP Care Coordinator

— Note

CC texted :
Good afternoon , I am sending you this information/attachment regarding the Back-to-School Bash in case you need extra resources for school supplies. I am also checking in to see if they have had any physical or behavioral health concerns too, let me know how you are all doing. Looking forward to hearing back from you!

PIHP Care Coordinator

Now, this is good!

Note

CC texted :

Care Coordinator provided Health Promotion and Care Coordination:

Attachment Name: COVID19 Stop The Spread of Germs:

Hello !!! This is , Care Coordinator for the PIHP from . It is the month of March and I believe we will see spring soon to our delight. However flu season still seems to be a huge issue lately, so please take precautions. I have attached the COVID19 Stop The Spread of Germs to this text above. Please give me an update on how you and are doing and take care of your health. If you have any concerns or needs please let me know by texting or calling me at this number or call the office at

PIHP Care Coordinator

Documentation excellence!

Asked member who she would like present at PCPS meeting and they would like care coordinator and *provider name*. We talked about who would lead the PCPS meeting, I empowered her to facilitate and lead where they felt comfortable. We talked about who else she would like to help lead process and she chose *care coordinator*. We talked about when and where she would like to have the PCSP meeting. They would like to have meeting at the *following place* and time 1.1.2020 at 10:00 AM via phone due to COVID 19. I looked at communication section of the InterRAi and noted member has no communications issues or concerns. I also asked if there were any special communication or cultural needs and that would be helpful for me to know for PCSP meeting and ongoing supports. They responded none. We talked about something what would happen if they did not agree with something during the PCSP process. They said they would feel comfortable talking to this care coordinator about any concerns. There are no conflict of interest concerns at this time.

This is great work!

FSS dropped off the yearly paperwork with Simone for her to review. FSS let Simone know that she has the option of utilizing a different [redacted] e chose. FSS asked Simone to call with any questions regarding the paperwork. Simone is planning on filling out the paperwork next week and then calling FSS to arrange r[redacted] the paperwork to FSS.

IHH Team provided family with Health Action Plan, Welcome Packet, assist with Value added benefits, Healthy Rewards Program, MCO member website / portal, etc. IHH Team encouraged the family to complete the health risk screener on the MCO portal, assist with Value added benefits, Healthy Rewards Program, MCO member website / portal, etc. Writer assessed the family's needs at this time and will follow up on any referrals as needed.

Behavioral Health and Physical Health crisis plans

“MY SELF – MANAGEMENT PLAN (CRISIS PLANS)

Documenting crisis plans: Behavioral health & Physical health

- Not just for behavioral/mental health
- Chronic disease education
- Collaboration with other service providers, community organizations
- Part of member care plan identifies:
  - BH and PH triggers
  - Member coping skills;
  - How to minimize triggers to avoid the ER/hospitalizations.
- Who monitors and/or follows – up with the member
- Alternative care education (i.e., PCP, Urgent care, etc.)

Crisis/Self- management plan: Mental health

Triggers

- Not taking medications as ordered
- Using drugs
- Being in one spot too long
- Not getting enough sleep

Indicators

- Refuse to participate in programming
- Will not make sense when he talks
- Increased isolation

Coping skills

- Going for walks
- Spend time with animals
- Listen to music
- Spend time with parents/grandparents

Crisis plan/Self – management plan: Physical Health Asthma

- Carry his inhaler on his person at all times
- Use inhaler as needed
- Notify staff when having problems
- Call 911 if further medical intervention is needed

Specific, Measureable, Attainable, Relevant, Time – bound

SMART GOALS

S.M.A.R.T. Goals
Are you using them?

Specific: What you hope to achieve or accomplish

Measureable: Indicators that help one stay on track to achieving goals

Attainable: can be realistically achieved on time and within available resources available

Relevant: is a logical way to achieve your goals

Time – bound: indicates a specific timeframe for achieving goals; has beginning and end time

S	M	A	R	T
• Short • Specific • Simple • **WHAT** will you do	• Measurable • Meaningful • **How much, how many, how often**	• Achievable • Attainable • You have tools & resources to attain goal	• Realistic • Relative to your life; worthwhile • Will it meet your needs and goals?	• Timeframe • Has a beginning & end • Answers **"WHEN"**

Writing a strong S.M.A.R.T. Goal

Goal: I want to communicate with my family more often.

Objective: I will talk with someone in my family this month.

S	M	A	R	T
Partial	**No**	**Yes**	**Yes**	**No**
Will talk with someone in my family	Is too vague; needs to be more specific and measureable	Member can build skills to talk with their family about relevant topics	Communication and involvement with family is important to my life	“This month” is vague and has no beginning or end

Writing a strong S.M.A.R.T. Goal

Goal: I want communicate with my family more often during the day.

Objective: I will start a conversation with a family member asking a relevant question about their day or shows they watch twice a day, four days a week for next 2 weeks, with only 2 verbal prompts from daytime staff member.

S	M	A	R	T
Yes: answers what, where, when, how and with whom	**Yes**: identifies "how often" and "how many"	**Yes:** I see my family daily and can ask them questions	**Yes:** Increases positive interactions and communication with my family	**Yes**: answers question of "when" and "for how long"
• Start a conversation • Asking a question • Four days/week • With 2 verbal prompts • By a daytime staff member	• Twice a day • Four days a week • Over 2 weeks • Only 2 verbal prompts	Relevant questions: I can ask about their day or shows they have watched.	This is a skill that is meaningful and important to me as I learn to talk with my family and other people about their day	Four days In 2 weeks

Health home example

RISK IDENTIFIED ON INTERRAI	Adult - Functional Status
SERVICE ACTIVITY	HBH - Adaptive Skill Development
GOAL	I want to improve my credit.
RATIONALE	is diagnosed with F25.9 Schizoaffective Disorder, Bipolar Type, F41.9 Generalized Anxiety Disorder, F43.9 Unspecified trauma-and stressor related disorder, F29 Unspecified psychosis not due to a substance or known physiological condition, F12.10 Cannabis use disorder which has led to impulsive spending, poor money management, and other taking advantage of her at times. will benefit from regular staff intervention to create a follow through with a budget and learning how to manage her finances more successfully.
DESIRED OUTCOME	will create and follow through with a budget to ensure she has her basic needs met.
INTERVENTIONS & SUPPORTS NEEDED (PROVIDER RESPONSIBILITIES)	1. Staff will encourage to meet with staff at scheduled times. 2. Staff will support with creating and reviewing a monthly budget, reviewing her bank accounts, talking to student loan companies, accessing her credit score, etc. 3. Staff will support with setting up payment plans to pay off old debt as needed. 4. Staff will encourage to stick to the budget she creates. 5. Staff will assist as needed through verbal prompts, modeling, and roleplaying. 6. Staff will praise for addressing her finances.

ACTION STEPS (MEMBER RESPONSIBILITIES)	**START DATE**	**END DATE**
I will review and discuss my finances at least 2x per month with staff, being successful at least 3 out of 4 months, 6/8/20 – 9/30/20. I will review and discuss my finances at least 3x per month with staff, being successful at least 3 out of 4 months, 10/1/20 – 1/31/21.	6/8/2020	1/31/2021

Alternatives to the ED for care

EMERGENCY DEPARTMENT UTILIZATION

Education and Documentation

DON'T:

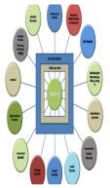
- Assume member understands the alternatives available to them
- Educate *after* ED or hospitalization only; be proactive
- Educate "one and done" or just tell member alternatives
- Hand them a brochure in place of "education"
- Forget to document member understanding, needs, barriers, concerns and outcomes

DO:

- Educate on alternatives before ED use or hospitalizations
- Document education *pre-emptively*
- Provide education on alternatives to ED use for primary care
- Identify your high utilizers; provide appropriate education and self-management support
- Document member understanding and/or questions/concerns/barriers
- Create action/crisis plans with the member (physical/behavioral health)
- Encourage use of nurse lines, PCP triage lines, etc.
- Use teach – back techniques

What does the member know?

Provide member useful information



Name/number of HH and care coordinator

Self – care

Crisis/Action plans for self – care

After – hours call information

Primary Care provider

Urgent Care provider

MCO care phone numbers

Nurse Line/Doc on Call

Crisis beds

Emergency Department

An “always” event

MEDICATION RECONCILIATION

How members can help with medication reconciliation

- Keep a current (up-to-date) medication list at all times
- Cross off medications no longer taking
- Put list where it can be found quickly
- Bring list to every primary care or other health care appointment
- Discuss all medications with member's provider(s)
- List any Over-the-Counter (OTC) medications, herbals taken or vitamins/minerals taken
- List any allergies or intolerances to medications and reaction
- **ASK QUESTIONS!**

Medication reconciliation and education

- Medications to be continued at home, in LTC, HAB home, etc.
- OTC meds, herbals, vitamins, etc. taken
- Name of medication or generic name of medication
- Dose
- Frequency/time of day to take medication
- Foods, drinks, activities to avoid while taking
- Taken with/without food or specific drink
- Form (pill, tablet, injection, patch, syrup, etc.)
- Route of administration
- Reason for use/Effect of use
- Expected duration of use (chronic, time – limited)
- Expirations or “use by” date
- What does “as needed” mean?
- How to store mediation
- Who administers medication?
- Ability to self – medicate
- Allergies/intolerances
- Side Effects
- What to do in an emergency
- Where do you store your medication?

Resource

Medication Checklist

Name:	▪ Brand name (or)	▪ Generic name
Dosage :	▪ 2 mg 1 tablet/capsule ▪ 2 mEq ▪ 2 ml/cc	▪ 2 gtts ▪ 2 puffs, etc.
Schedule:	▪ qd (every day) ▪ bid (two times a day) ▪ tid (three times a day) ▪ qid (four times a day) ▪ monthly	▪ prn (as needed) o **frequency must be documented (ie: q 4 hours or NTE 4 doses/24 hours)**

Things to Remember:

☐ **Reconcile medications with member.**

- *Check Member 360 pharmacy claims.*

☐ **Does the member understand each medication? *Use teach back method**

- *If member does know follow this example: "Fioracet, member is unable to recall dose, reports that she takes 1 tablet every 4-6 hours PRN for migraine. CM will follow up with member on dose at next outreach, if unknown CM will follow up with provider."*

☐ **Does the member have barriers to taking medications?**

- *If yes, document barriers and make sure to follow up on barriers in subsequent contacts/documentation.*
- *If no, document, "Member did not identify any barriers to taking medications."*

☐ **Is member taking herbals, supplements, over the counter (OTC) medications and/or PRN's?**

- *If yes, document including how often and why. (ie: Multivitamin 1 tablet daily)*
- *If no, document, "Member is not taking any OTC medications or herbal supplements."*

☐ **Use complete documentation of medication in follow up notes, as well as the initial assessment note.**

- *"Member was prescribed Prozac 20 mg daily @AM, due to new clinically significant depression symptoms. Member reported an understanding of this medication and did not identify any barriers to taking Prozac."*

Important questions to ask

- How is the information transferred or “linked” to member’s permanent record?
- Who is responsible for signing off the medication reconciliation process?
- Who is responsible to pass along the list and to which provider(s)?
- How do you transfer this information to the member’s personal medication list?

Health Homes and all service providers working together

PROVIDER COLLABORATION

What does collaboration look like?

Collaboration in health care is defined as **health care professionals assuming complementary roles and cooperatively working together**, sharing responsibility for problem-solving and making decisions to formulate and carry out plans for patient care. Collaboration between physicians, nurses, and other health care professionals increases team members' awareness of each others' type of knowledge and skills, leading to continued improvement in decision-making.

O'Daniel M, Rosenstein AH. Professional Communication and Team Collaboration. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 33.

Health Home example of care coordination and collaboration

Visit Date: 09/10/2020

Reason For Visit

- IHH Service Provider: Care Coordinator• Care Coordination Writer alerted by Director of Services with that was taken to the ER for suicidal ideations and hallucinations.

Writer contacted by , renewed case and concerns on complex medications. Follow up with from . Member is currently on banned list

Visit Date: 09/11/2020

Reason For Visit

• Phone 2:41 pm, Writer spoke with member to follow up. (Member currently hospitalized at , IA). Member reported he "could be better" and stated that he was not safe and had a chance of over-dosing, and gave staff his medications. Member mentioned that before he would not ask for help and was glad he did this time. Member reported he arrived too last last night to see the DR and did not receive medications, though he did see the DR today and was finally given his medications. Member does not recall the DR's name. Member reports he did not sleep well due to this. Writer discussed follow up with , member was agreeable to this. Discussed appointment with his therapist, with . Writer to follow up with Staff. Member brought up concerns with work and getting a job coach, discussed how health is important during this time. asked "So you're possibly thinking I won't be able to work for a while". Writer encouraged member to follow up with both and about it, but it's important for health currently because of hospitalization. Writer did ask member if he was currently experiencing anxiety, which member did report he was. Writer encouraged member to speak with nurse to see if the DR had prescribed PRN. Writer offered to speak with nurse, member declined and stated that he could ask.

Member pending discharge on Monday / Tuesday• IHH Service Provider: Care Coordinator• Care Coordination 12:52 pm, Writer reached out to with . (Where member is currently hospitalized) ROI on file. to provide contact info for member's assigned social worker.

2:37 pm, Writer returned phone call (Social Worker from). Member planned discharge on Mon/Tue. Hosp to arrange MCO transportation. Writer to work on 7 day follow up wit , ,

2:58 pm, Writer sent the following email out to - , , anc :
Hi all-

Spoke with (social worker) and . He did share that he saw the DR today and was able to give him meds. He's expected to be discharged on Mon/Tue- with MCO transportation.
I wanted to touch base as he said that he has bi-weekly appointments with with for therapy. Do you know when he was last scheduled? I'm working to get him in with .

3:04 pm, Writer provided update to and nurses. Writer emailed asking for follow up appointment

Transitions within the community

TRANSITION OF CARE

Root causes of ineffective transitions of care

- Communication breakdowns
- Patient education breakdowns
- Accountability breakdowns

Joint Commission Resources: “Improving Transitions of Care,”

Communication breakdown

- Expectations differ between senders and receivers of members in transition
- Culture does not promote successful hand-off (e.g., lack of teamwork and respect)
- Inadequate amount of time provided for successful hand-off
- Lack of standardized procedures in conducting successful hand-off

Joint Commission Resources: “Improving Transitions of Care,”

Patient education breakdowns

- Conflicting recommendations
- Confusing medication regimens
- Unclear instructions about follow-up care
- Members/family may be excluded from the planning related to the transition process
- Member may lack a sufficient understanding of the medical condition or plan of care

Joint Commission Resources: “Improving Transitions of Care,”

Accountability breakdowns

- No physician or clinical entity takes responsibility to assure member's health care is coordinated across various settings and providers
- Primary care providers are sometimes not identified by name; limited discharge planning and risk assessment
- Steps are not taken to assure sufficient knowledge/resources will be to member upon discharge.

Joint Commission Resources: "Improving Transitions of Care,"

Breakdown example

Sally Sue hospitalized at Mercy on 6.23.2020 for hallucinations. Called nurse to find out what plan was for discharge and did not hear back. Found out later Sally Sue discharged over weekend. This worker will follow up next week to see how member is doing.

This looks great!

1.18.2020

Joan Jett hospitalized at St. Luke's Hospital on 1.16.2020 for SI, taken in by staff when they found her alone in her room crying.

Received notification that member was hospitalized from MCO. Called and spoke with nurse at St. Luke's. Member is well known at St. Luke's and seems to be back at baseline. Member will most likely be discharged on 1.21.2020 with medication changes made. Let nurse know what services Joan had in place, day hab on Tues./Thurs. Member also has supported employment two days per week, but has been complaining this is too much pressure to work 30 hours. Member does see Dr. Smith for medication management and John Stamos for therapy 2/month. Since member is in 24 hour site home, I will follow up to request update from staff at site home. Discussed member mentioning she would be more comfortable with female therapist, but didn't want to hurt current therapist feelings.

Agreed that this care coordinator will follow up with ABC Solution Therapy today and set up 7 day follow up and request new therapist.

Discussed medication changes and Joan will increase Dexedine to 15 mg. 3 caps daily to 4 caps daily.

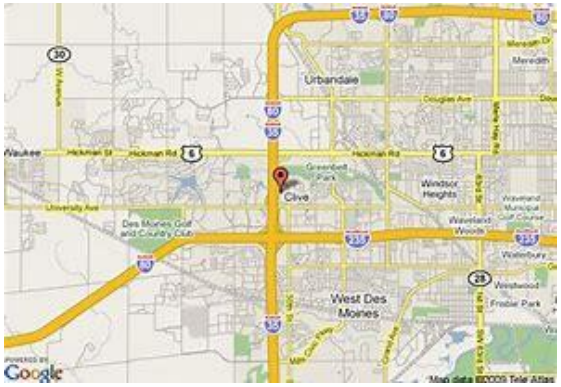
Every one. Every member. Every time.

POLICY AND PROCEDURE

Getting from here to there

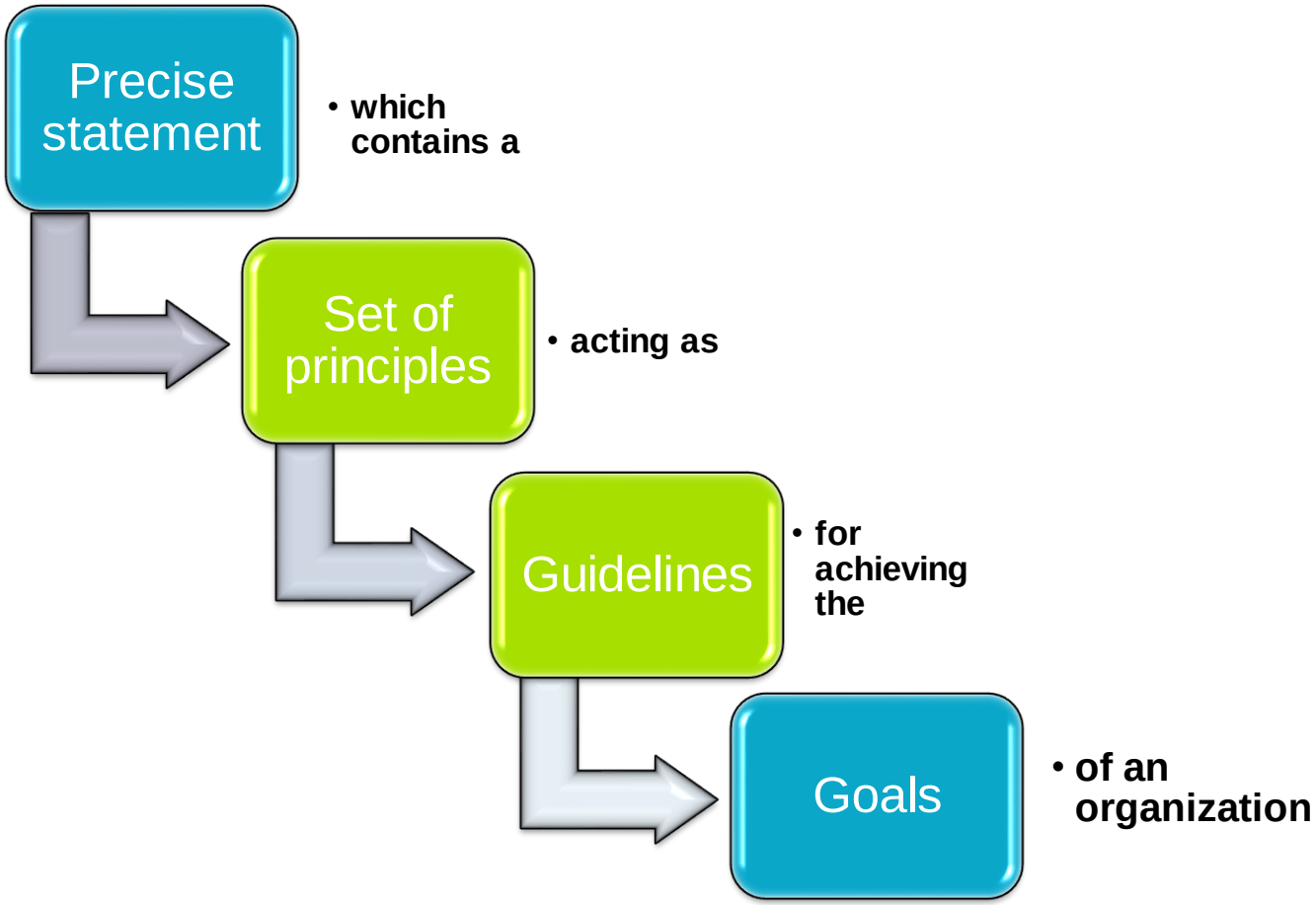
Policies: *principles acting as guidelines; drive process/procedure*

Processes: *high level view; tasks identified*



Procedures: *detailed steps or sequences required to perform activity within a process*

What is POLICY?



What is PROCESS?

- Service or product
- Crosses departments of functional areas
- Designates contact points
- Presents total process
- Tool: Process map
- Addresses:
  - Who
  - What
  - When

What is PROCEDURE?

Specific → Sequential → Logical → Action – oriented → Who, what, when, how

Step 1: Wet hands under running water

Step 2: Add soap

Step 3: Rub well for 20 seconds

Step 4: Rinse well under running water

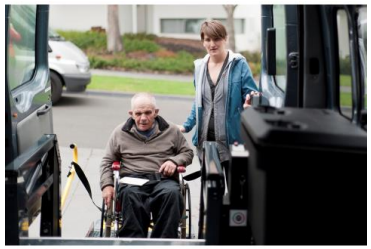
Step 5: Dry hands with clean towel

Step 6: Turn off water with towel

When do you need a procedure?

- Is lengthy
- Is complex
- Is routine, but it's essential that everyone strictly follows rules
- Demands consistency
- Involves documentation
- Involves significant change
- Has serious consequences if done wrong

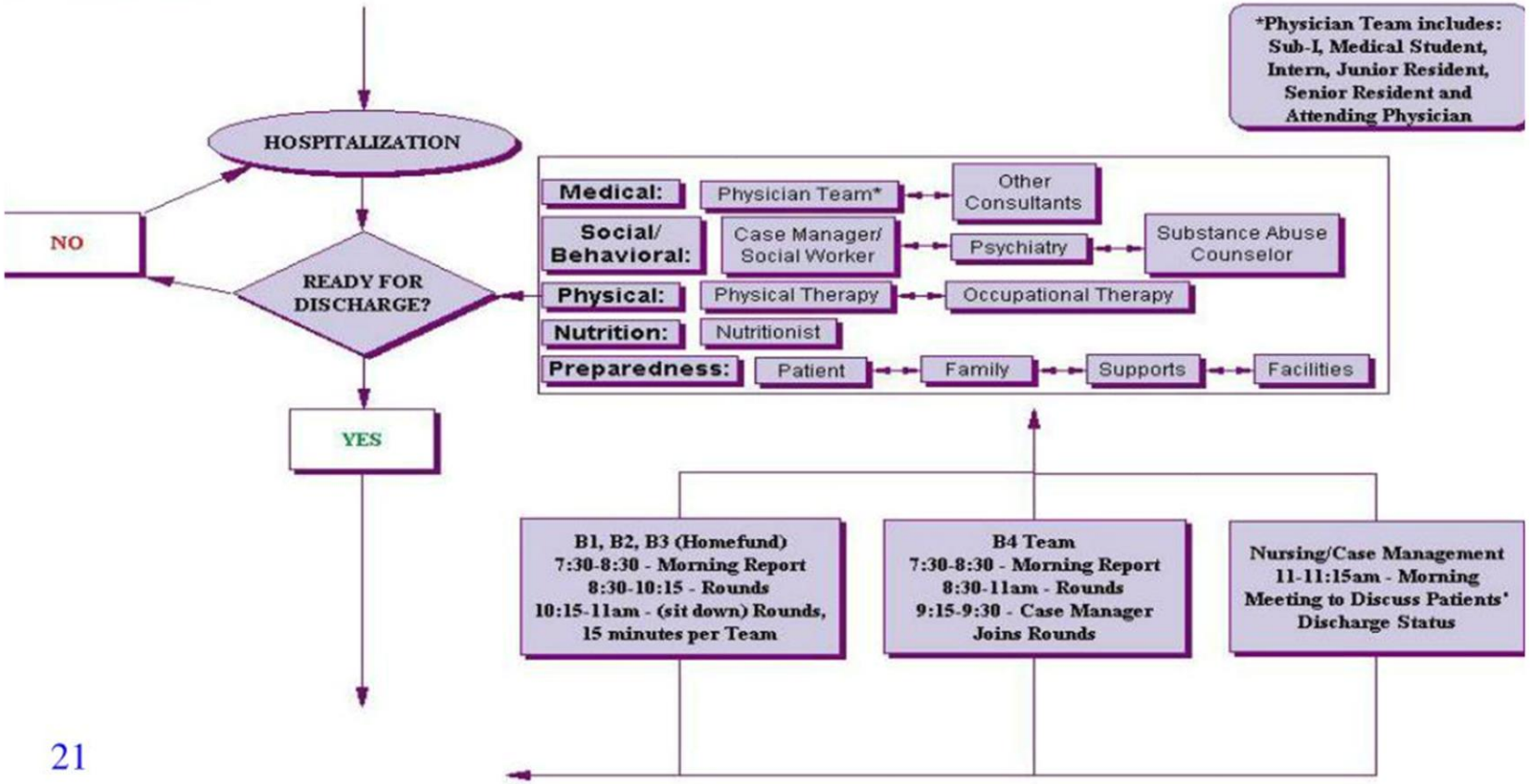


You need a procedure when:

- Similar questions are asked repeatedly.
- People seem confused.
- There are too many ways that people interpret the procedure.

Process Mapping-1
Ready for Discharge?



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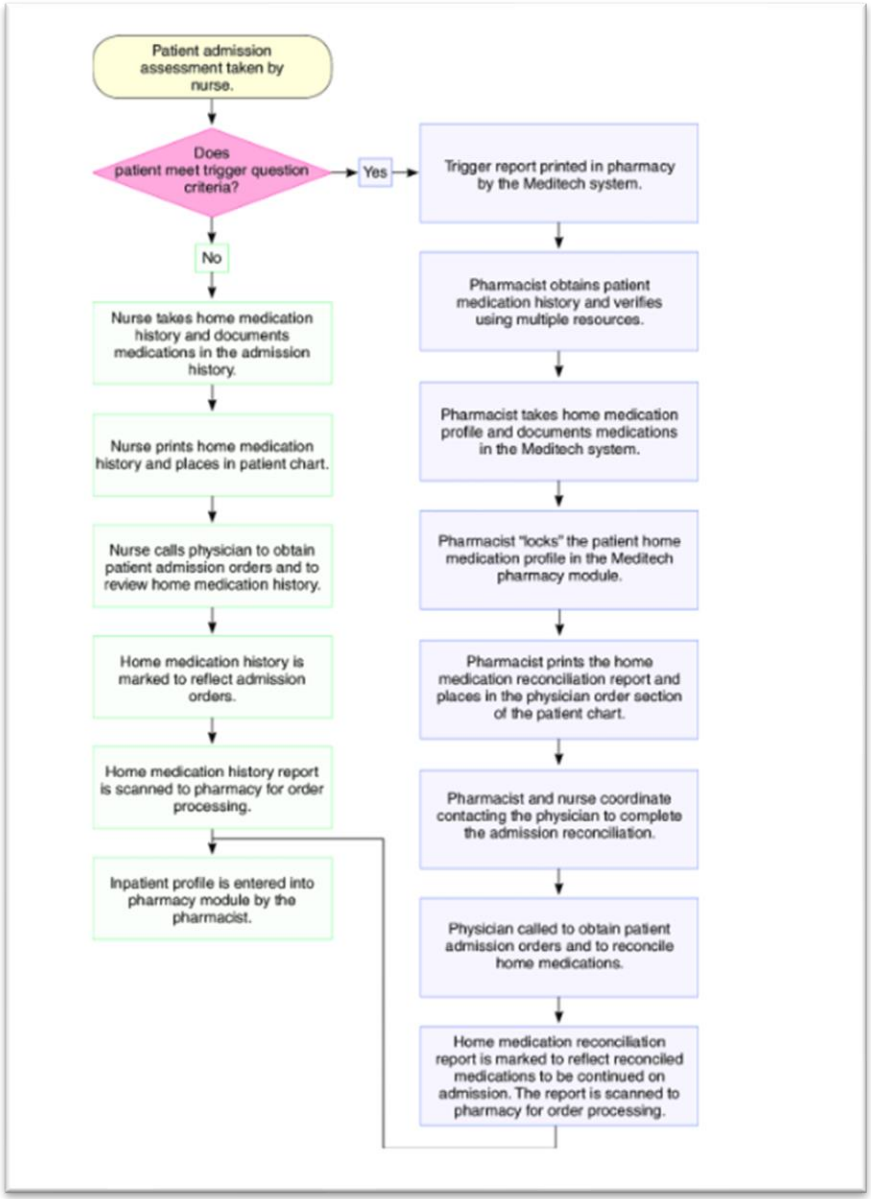
PROCEDURE


Patient admission assessment taken by nurse.
Does patient meet trigger question criteria?
Yes
No
Trigger report printed in pharmacy by the Meditech system.
Pharmacist obtains patient medication history and verifies using multiple resources.
Pharmacist takes home medication profile and documents medications in the Meditech system.
Pharmacist "locks" the patient home medication profile in the Meditech pharmacy module.
Pharmacist prints the home medication reconciliation report and places in the physician order section of the patient chart.
Pharmacist and nurse coordinate contacting the physician to complete the admission reconciliation.
Physician called to obtain patient admission orders and to reconcile home medications.
Home medication reconciliation report is marked to reflect reconciled medications to be continued on admission. The report is scanned to pharmacy for order processing.
Nurse takes home medication history and documents medications in the admission history.
Nurse prints home medication history and places in patient chart.
Nurse calls physician to obtain patient admission orders and to review home medication history.
Home medication history is marked to reflect admission orders.
Home medication history report is scanned to pharmacy for order processing.
Inpatient profile is entered into pharmacy module by the pharmacist.

Resources

Integrated Health Home State Plan Amendment (SPA)
Integrated Health Home (for Providers) | Iowa Department of Human Services

Chronic Condition SPA
Chronic Condition Health Home (for Providers) | Iowa Department of Human Services

Process Map Process and Tool: (included with the slide deck email)

Chart Review Workbook: (will be posted on the IME Health Home websites)

Thank you!